National Eating Disorders Collaboration

National Practice Standards for eating disorders

National Eating Disorders Collaboration | nedc.com.au

National Eating Disorders Collaboration | nedc.com.au

The National Eating Disorders Collaboration is funded by the Australian Government Department of Health.

This document was first published in February 2018 and last updated in January 2020.

1. ACKNOWLEDGEMENT

The National Eating Disorders Collaboration (NEDC) is a collaboration of people and organisations with an expertise and/ or interest in eating disorders. It brings together expertise, research evidence and experience to develop a nationally consistent, evidence-based approach to the prevention and management of eating disorders in Australia. **www.nedc.com.au**

Collaboration, defined as the act of 'voluntarily and cooperatively working together to achieve a common goal' is the core operating principle of the National Eating Disorders Collaboration (NEDC).

The contribution from NEDC stakeholders, interest groups and members to these standards and the reports they are drawn from has been invaluable in shaping our understanding of the opportunities and challenges of implementing eating disorders prevention and treatment initiatives and has enabled the NEDC to develop a more complete and accurate picture of what is happening with regards to eating disorders in Australia.

The NEDC also acknowledges the considerable work that has already been undertaken by a number of state governments and academic institutions on professional development for a skilled eating disorders workforce and identification of opportunities for improved service for people with eating disorders. We would particularly like to acknowledge the contribution of the Australia and New Zealand Academy of Eating Disorders (ANZAED), InsideOut Institute, The Butterfly Foundation, Eating Disorder Outreach Service (QLD), Eating Disorder Training and Evaluation Centre (WA), and the Victorian Centre for Excellence in Eating Disorders.

Particular thanks must also go to the Steering Committee of the NEDC who have provided expert leadership for the development of this document.

National
Eating Disorders
Collaboration

CONTENTS

2. CONTEXT

2.1. EATING DISORDERS IN AUSTRALIA

Eating disorders are a group of serious psychiatric illnesses which includes anorexia nervosa, bulimia nervosa, binge eating disorder, and other eating and feeding disorders (Hay et al, 2014). Each of these disorders involves distinct behaviours and beliefs specific to the diagnosis and treatment can vary depending on the diagnosis. However, people with all types of eating disorders share disturbed eating behaviours and distorted beliefs, with extreme concerns about weight, shape, eating and body image. Symptoms can also include driven exercise.

Eating disorders are highly complex, serious mental illnesses with significant physical complications and impairment including chronic heart and kidney disease, osteoporosis and diabetes and other metabolic illnesses. Physical health problems are often severe enough to warrant urgent medical care, although this is often not sought (Bravender et al, 2016). Individuals with eating disorders have significantly elevated mortality rates (Arcelus et al, 2011)

Most people with an eating disorder present with binge eating disorder or other eating and feeding disorders (Hay et al, 2008). These disorders are as clinically severe as anorexia nervosa and bulimia nervosa (Hay, Buttner, Mond, et. al, 2010), with an elevated mortality rate and increased risk of suicide comparable to that of anorexia nervosa (Crow et.al, 2009).

All eating disorders are serious illnesses with high levels of psychological distress, risks of long-term mental illness, medical complications and an increased risk of premature death due to medical complications and to an increased risk of suicide. Eating disorders have been shown to have one of the highest impacts on health-related quality of life of all psychiatric disorders (AIHW, 2008).
Eating disorders most frequently start in childhood and youth and impact on education, identity formation and physical growth. With a high risk of recurrence and chronicity, eating disorders can impact on health and quality of life for the whole life span. For families, the impact may include caregiver stress, loss of family income, disruption to family relationships and a high suicide risk (NEDC, 2010).

Eating disorders are relatively common when compared with other priority health issues, affecting approximately 9% of the total population with prevalence in any one year of around 2.9% in males and 5.4% in females (Fairweather et al, 2014; NEDC, 2012).

The rate of eating disorders in the Australian population is increasing (Hay, et al., 2008). This trend is most evident in binge eating disorder and has paralleled the increase in children with high body mass index (BMI) (O'Dea, 2005).

Eating disorders are a distinct group of complex illnesses with treatment requirements that are different to other types of mental illness. The complexities of eating disorders require a long term multi-disciplinary team approach, integrating medical, nutritional and psychological treatment delivered in a supportive environment.

Implementation translates evidence into practice. The NEDC has developed a suite of evidence informed reports and resources that together outline evidence from research, clinical expertise and lived experience of eating disorders.

2.2. PURPOSE AND SCOPE OF STANDARDS

This set of standards is intended to strengthen the workforce and to outline the values, attitudes, knowledge and skills required of individuals, services and systems to successfully respond to eating disorders. Implementing the practice standards will promote a coordinated and consistent approach to professional development and service improvement.

This document is to be read in conjunction with the relevant state and federal legislation and Australian professional codes of conduct or practice, including:

- National Eating Disorders Framework National Eating Disorders Collaboration (NEDC) (2012). An Integrated Response to Complexity: National Eating Disorders Framework. Report to the Australian Government Department of Health and Ageing, March 2012. NEDC: New South Wales, Australia.

- Clinical Practice Guidelines Hay, P., Chinn, D., Forbes, D., Madden, S., Newton, R., Sugenor, L., Touyz, S. & Ward, W. (2014). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Australian & New Zealand Journal of Psychiatry, 48(11): 1–62. Available from: www.ranzcp.org/

- Service Implementation Guide National Eating Disorders Collaboration (NEDC) (2014). Practical Responses to Eating Disorders: A Guide to Implementing Responses to Eating Disorders in General Health Services. Available from www.nedc.com.au

- Stepped Care Approaches to Eating Disorders National Eating Disorders Collaboration (NEDC) (2017). A guide to a stepped care approach for eating disorders in community integrated approaches to care. Resource available from www.nedc.com.au

- Insights in Recovery Guide Butterfly Foundation (2016). Insights into Recovery from Eating Disorders: A consumer-informed guide for health practitioners working with people with eating disorders. Sydney, Mental Health Commission of NSW. www.thebutterflyfoundation.org.au

- National Framework for Recovery-oriented Mental Health Services The Department of Health (2013). National framework for recovery-oriented mental health services: Policy and theory. Canberra: Commonwealth of Australia. Available from: www.health.gov.au

3. PRINCIPLES

The following practice and implementation principles are described in the National Eating Disorders Framework (NEDC, 2012). These principles provide the foundation for an effective and nationally consistent approach to eating disorders.

3.1. PRACTICE PRINCIPLES

Recovery-oriented person and family-centred care

Individual treatment plans are developed within a person-centred, family and culture-sensitive and recovery-oriented framework. Services are delivered with a strengths-focused approach, supporting long-term recovery, tailored to meet individual decision-making capacity and needs as they develop over the course of the illness; and

Prioritisation of early identification and early intervention

Early identification and prompt intervention are necessary to reduce the severity, duration and impact of the illness. People have access to services as soon as they are needed: early in the development of the illness, early in help-seeking and early in recurrent episodes of illness, with immediate access to treatment and support; and

Safe treatment options

Safe treatment for eating disorders addresses all of the aspects of illness assisting people to meet their physical, psychological, behavioural, nutritional, occupational and social needs. Treatment is provided by a multi-disciplinary team who work in partnership with the person, their family, and other health and support providers, including treatment of co-morbid issues; and

Flexible treatment and recovery pathways

People have access to a range of safe treatment options which meet different needs at each stage of risk, illness and recovery. Clearly identified entry points, ideally located in the community, assist people to make informed decisions about treatment options and engage with accessible services. Community-based recovery support is integrated into treatment pathways; and

Equity of access and entry

People have access to treatment and support services when and where they are needed, early in the illness and early in each episode of illness. The requirements of regional and rural areas are recognised and technological solutions to providing accessibility are provided. The entry requirements and the costs, subsidies or fee rebates for treatment take into consideration the long-term and complex nature of eating disorders and the need to ensure they are accessible and affordable to all; and

Support for families and carers as integral members of the team

Families and carers are recognised as integral members of the treatment and support team. They receive support, skills and strategies, education and information to enable them to support the person with an eating disorder and to maintain personal good health.

3.2. IMPLEMENTATION PRINCIPLES

Evidence-informed and evidence-generating approaches

Research and evaluation are integral to the design and delivery of health promotion, prevention, early intervention, and treatment approaches for eating disorders. People with personal experience of eating disorders are involved at all levels of research, service development and evaluation; and

A skilled workforce

All health professionals working with high-risk populations and all professionals required to work in the multidisciplinary team receive training in eating disorders to raise their awareness of the serious nature of eating disorders and to enable them to identify, assess and contribute to the treatment of eating disorders; and

Accessible tertiary consultation

Wherever treatment occurs in the continuum of care from early intervention to recovery support there must be access to tertiary-level expertise for consultation, supervision, guidance and referral if required; and

Evidence-based community communication

Consistent and appropriate messages are provided to make sure that the community is aware of eating disorders as serious mental and physical illnesses. Eating disorder prevention integrates with wider physical and mental health promotion strategies to provide consistent health information that promotes wellbeing; and

Systems support integration and collaboration

Policy and systems support collaboration between physical and mental health services, private and public health services, health promotion, prevention and treatment, health and community services and between professional disciplines. People with personal experience of eating disorders are involved at all levels of policy development, planning and systems development.

4. CORE SERVICE CAPABILITIES

Essential steps for all medical and mental health services working with people who have, or are at high risk of developing eating disorders.

COLLABORATION	Networks support multidisciplinary care • Virtual teams/professional networks • Established relationship with tertiary centre • Protocols support collaboration and shared care
CAPABILITY	Professional Development • All staff have knowledge and skill to identify eating disorders • Selected staff are skilled to provide assessment and/or treatment intervention as part of a share care team
CORE BUSINESS	Eating disorders are identified as a service priority • Risk management strategies and policies include eating disorders • Identified role responsibilities for eating disorders
COMMUNITY PROGRAMS	Programs Development • Service planning includes investigation of need for eating disorder specific responses

5. STANDARDS

5.1. INTEGRATING WITH CORE PRACTICE

STANDARD	STANDARD IN ACTION
Eating disorders identified as being an important community health concern and serious mental health issue requiring a coordinated response.	• Connection made with a nationally recognised eating disorders service and/or local eating disorders program providers as relevant to services delivered • Identified staff member(s) to represent the organisation or practice to the eating disorders sector.
Eating disorders are prioritised as part of any focus on mental health and allied physical health concerns.	• Services run or commissioned which address mental health include eating disorders and how they will respond to them in their service documentation. • Relevant staff meet workforce core competencies • Eating disorders are included in screening and assessment tools/ processes. • There are identified role responsibilities for eating disorders within mental health and sufficient time allocation to undertake these roles. • Risk management strategies and policies relating to mental health include eating disorders.
Service and system planning includes investigation of ED needs in primary care setting.	• Eating disorders are addressed in key needs analysis, strategic and planning documentation. • Organisation or practice collects data regarding eating disorders to inform future needs and service planning.

5.2. PROVIDING APPROPRIATE INFORMATION AND COMMUNICATIONS

STANDARD	STANDARD IN ACTION
Evidence-based information on eating disorders is disseminated in ways that are useful to their audiences.	• Utilises the latest information on eating disorders from reputable sources. • Eating disorders information is included in internal and external resources on relevant health issues including mental health and chronic illness. • Organisations or practices share eating disorders resources and/or information with their workforce and other stakeholders.
Communicates about eating, weight, body image and eating disorders in a way that reduce the risk of harm.	• Internal and external communications adhere to the Mindframe Guidelines for eating disorders. • Use of anthropomorphic measurements is appropriate, medically necessary and undertaken by qualified professionals.

5.3. SUPPORTING PRACTICE AND SYSTEMS

STANDARD	STANDARD IN ACTION
Available resources and tools are used to assist in implementing integrated community responses to eating disorders.	• NEDC documentation on nationally consistent approach to eating disorders integrated with policies, plans and models. • Organisation or practice has systems in place for dissemination of information and professional development. • Resources and tools are made available to staff and healthcare workforce on identification, assessment, treatment and referral.
Practitioners are able to understand eating disorders and address them in ways appropriate to their role.	• Organisations and practices have the tools to provide or access ongoing training regarding eating disorders in their own regions. • Workforce are confident in implementing knowledge in their practice. • Information on professional development opportunities is regularly reviewed and shared with relevant internal stakeholders.
Participates in collaborative, local relationships to ensure appropriate, consistent primary care for those with eating disorders.	• Referral pathways identified, established and reviewed, including access to tertiary eating disorders care. • Collaborative care is facilitated and encouraged.

5.4. DELIVERY OF QUALITY, EVIDENCE-BASED CARE

STANDARD	STANDARD IN ACTION
Consumers with experience of an eating disorder and their carers are involved in development, implementation and evaluation.	• A consumer representative with a lived experience of an eating disorders sits on consumer boards/committees within the organisation, practice and/or system. • Services provided or commissioned have documented processes to receive and action feedback from those with a lived experience.
Eating disorders services that provided or commissioned are evidence-based and incorporate regular review and evaluation.	• Commissioning or funding bodies have tools to compare proposals to best practice evidence. • Organisations access eating disorders expertise for advice on services when required. • Service delivery is in line with evidence base on treatment model, dosage and duration.
Services are provided across the continuum of care for eating disorders.	• Services provided or commissioned which address mental health or chronic illness include consideration of eating disorders. • Those seeking treatment for an eating disorder are able to access effective, early intervention within their community. • Organisations involved in health care planning or delivery in federal, state and local jurisdictions have a plan for implementing services across the continuum.

6. WORKFORCE CORE COMPETENCIES

Competencies refer to the demonstrable skills and knowledge that are required to work in a particular field. There are currently no defined competencies for the treatment of eating disorders in Australia.

Core competencies provide a benchmark of standards against which skills and performance can be assessed. The adoption of a competency-based approach has a number of potential benefits including:

- Communicating the current evidence, principles and priorities for treatment of eating disorders
- Encouraging transparency of standards, expectations and accountability
- Promoting professional development and the improvement of current work practices;
- Assisting in the identification of training needs and the design of training activities and programs
- Promoting flexibility and the potential for individualisation of training
- Assisting with assessment for recruitment purposes (based on Leung, 2002).

These core competencies outline capabilities that all health professionals should achieve in their work with eating disorders. They are intended to complement discipline-specific practice standards or competencies of relevant professions including but not limited to; general practice, paediatrics, psychiatry, psychology, nursing, dietetics, social work and occupational therapy. They do not reflect the skills or specific competencies necessary to expertly deliver treatments specific to eating disorders care.

Different workplaces and degrees of specialised practice require different levels of competency, varying on a spectrum from professionals who are solely involved in early identification to professionals providing specialist eating disorder treatment and varying across service settings.

Five functional groups have been identified who play an important role in the identification and treatment of eating disorders. These functional groups are defined by the role they play in relation to the patient with an eating disorder and not by profession. Core competencies are those relevant to all functional groups appropriate to their role. Core competencies do not address the expert knowledge or modality skills required to deliver evidence-based medical, psychological or dietetic treatment for eating disorders.

Early identifiers

Early identifiers have a duty of care for the wellbeing of people in high risk groups for eating disorders and who are most likely to act as the first point of contact for people with eating disorders and their families. The role of early identifiers is to proactively engage people at risk to promote prevention and early help seeking.

Initial responders

Primary health care providers who provide the first level of intervention, such as screening, initial assessment, initial diagnosis, and referral. Where safe and appropriate after a thorough eating disorder assessment, professionals in this group may also provide guided self-help for people with bulimia nervosa and binge eating disorder.

Shared care treatment providers

Health professionals who provide treatment or support for the consequences of an eating disorder (e.g. medical monitoring and treatment) or for comorbid conditions. Professionals in this group are part of the interdisciplinary and interagency treatment team but are not providing therapy specific to the eating disorder.

Eating disorders treatment providers

Health professionals delivering eating disorder specific treatment that is safe (addressing all aspects of illness) and delivered through a collaborative multi-disciplinary team or shared care approach.

Recovery support

People providing professional support to those who are learning to self-manage their recovery from an eating disorder and to families and carers – this group includes the professions most likely to act as early identifiers and initial responders as well as treatment providers.

6.1. CORE COMPETENCIES BY FUNCTIONAL GROUP

Core competency area	Functional group				
	Early identifiers	Initial responders	Shared care professionals	Treatment professionals	Recovery support professionals
1. General knowledge of the clinical features of eating disorders, common treatments and the individual experience of recovery	Required	Required	Required	Required	Required
2. Ability to identify warning signs of eating disorders and disordered eating and to conduct initial assessment within the scope of usual professional role	Required	Required	Required	Required	Required
3. Ability to engage the person with an eating disorder and family in a non-judgemental manner and to motivate engagement with and refer to relevant health services and treatments	Required	Required	Required	Required	Required
4. Ability to support the person and their family to facilitate personal recovery		Required	Required	Required	Required
5. Ability to contribute to multi-disciplinary team assessment, care planning and treatment within scope of usual professional role			Required	Required	Required
6. Knowledge of current clinical practices and standards in the treatment of eating disorders			Required	Required	Required
7. Ability to deliver an evidence-based treatment for eating disorders				Required	

6.2. UNITS OF COMPETENCY

Competency area	Units of competency
1. General knowledge of the clinical features of eating disorders, common treatments and the individual experience of recovery (required of all health professionals)	a. General knowledge of developmentally appropriate healthy eating, nutritional principles and healthy relationships with food
	b. Ability to describe eating disorders, their progression and impact on psychological health and quality of life
	c. Awareness of the overlapping nature of eating disorders and the prevalence of atypical presentations
	d. Ability to describe the range of physical issues related to eating disorders
	e. Ability to explain the impact of rapid weight loss, and/or very low BMI on cognition
	f. Awareness of a variety of health conditions which can co-exist with eating disorders (e.g. diabetes, depression)

Competency area	Units of competency
2. Ability to identify warning signs of eating disorders and disordered eating and to conduct initial assessment within the scope of usual professional role (a-e required of all health professionals) (f required of shared care management and eating disorder treatment professionals) (g-i required of recovery support professionals)	a. Ability to recognise the signs of disordered eating and describe the associated health risks
	b. Knowledge of warning signs and red flags
	c. Ability to take a preliminary case history relevant to eating disorders using culturally respective practice
	d. Assess for risk of suicide and self-harm
	e. Use assessment tools and tests as appropriate for the person and the professional discipline (e.g. SCOFF, EDE-Q, EDI, RMI, HEADSS, EAT-26, BEDS-7, etc.)
	f. Contribute to the comprehensive assessment of children, adolescents and adults in relation eating disorders
	g. Discuss the risk of relapse and the importance of recovery support
	h. Describe secondary prevention strategies
	i. Ability to conduct strengths-based assessment, collaborating with the person to identify their strengths, risks for relapse and individual needs for support

Competency area	Units of competency
3. Ability to engage the person with an eating disorder and family in a non-judgemental manner and to motivate engagement with relevant health services and treatments (a-f required of all health professionals) (g required of shared care management, eating disorder treatment and recovery support professionals)	a. Ability to demonstrate an empathetic understanding of high levels of ambivalence and fear of change in people with eating disorders
	b. Discuss the barriers to self-disclosure that a person with an eating disorder may experience and strategies to deal with these barriers
	c. Demonstrate knowledge of services and systems in your region appropriate for the treatment of eating disorders
	d. Refer people with eating disorders to relevant services to address their physical, psychological and nutritional needs
	e. Identify when the person should be referred directly to an eating disorders specialist service
	f. Identify when a person with an eating disorder needs an urgent medical assessment or psychiatric assessment and when they should be referred to a Hospital Emergency Department
	g. Demonstrate awareness of personal attitudes, values and beliefs (e.g. body shape) to manage the potential impact of collusion with a person with an eating disorder

Competency area	Units of competency
4. Ability to support the person and their family to facilitate personal recovery (a-e required for all professionals) (f-g required for eating disorder treatment professionals) (h-j required for recovery support professionals)	a. Ability to engage parents/carers/partners and assess their concerns recognising that symptoms may be minimised by the person with an eating disorder
	b. Ability to encourage patients to allow their family to share information with the treatment team
	c. Provide appropriate follow-up for people referred for treatment
	d. Demonstrate knowledge of support services available for people with eating disorders and their families and provide information
	e. Ability to manage a person with an eating disorder who is waiting for treatment
	f. Ability to provide professional guidance to people with BN and BED who are working through a self-help program
	g. Work collaboratively with and support family members and identified support people
	h. Explain the range of education and support needs a person with an eating disorder and their family/support people may require
	i. Demonstrate awareness of community-based supports and resources and refer people to appropriate services
	j. Recognise indications of relapse and support people to re-access treatment services

Competency area	Units of competency
5. Ability to contribute to multi-disciplinary team assessment, care planning and treatment within scope of usual professional role (a-f required of shared care management professionals, eating disorders treatment professionals and recovery support professionals) (g required of recovery support professionals)	a. Understand how care teams are set up including the range of professions required to safely address all aspects of illness
	b. Describe the roles of key professions in the multidisciplinary team including: GP, Psychologist, Psychiatrist, Dietitian, Dental Practitioner, Mental Health Nurse, OT, Social Workers, Paediatricians
	c. Within usual role, work collaboratively with professionals from other disciplines to implement and review management plan, and to reduce the risk of patient's "splitting" health care providers
	d. Monitor progress and measure outcomes (relevant to own professional discipline)
	e. Support transfer between services and service providers
	f. Know the limits of personal expertise and when to seek advice or refer on to other colleagues in the shared care team
	g. Within scope of usual role demonstrate ability to provide one or more of the following: Information; Case management; Family education and support; Peer support; Recovery education; General counselling; Meal support

Competency area	Units of competency
6. Knowledge of current clinical practices and standards in the treatment of eating disorders (a-e required of shared care management professionals and eating disorders treatment professionals) (f-i required of eating disorders treatment professionals)	a. Describe the standards for safe treatment (National Standards Schema)
	b. Describe the medical and nutritional care that may be required to treat eating disorders
	c. Describe the role of treatment for medical consequences of eating disorders and of comorbid mental conditions including hospital admission, including intensive treatment and hospital admission
	d. Describe the purpose of weight gain for people with malnutrition
	e. Discuss issues in the care of adults with long term eating disorders
	f. Knowledge of specific evidence based psychological and pharmacological treatments
	g. Knowledge of the clinical practice guidelines for treatment of DSM-5 feeding and eating disorders
	h. Be aware of the risks of re-feeding syndrome, and the need for specialist care in nutritional restoration
	i. Demonstrate awareness of the circumstances when involuntary treatment may be necessary

Competency area	Units of competency
7. Ability to deliver an evidence-based treatment for eating disorders (required of eating disorder treatment professionals only) (e required of psychologists and mental health service providers only)	a. Describe a range of evidence supported treatment modalities for eating disorders and their relevance to individual needs including: CBT, Guided Self Help CBT, FBT
	b. Implement strategies to enhance motivation for change
	c. Utilize relevant tertiary services for professional training, case conferencing, supervision and referral
	d. Refer people with eating disorders for treatment of comorbid conditions where appropriate
	e. Ability to implement at least one evidence based treatment modality for eating disorders e.g. CBT-E, Guided Self Help CBT, FBT

7. AN INTEGRATED STEPPED CARE APPROACH

The national standards schema (NEDC National Framework 2012) for eating disorders stresses the necessity for access to integrated services, regardless of a person's geographic location, age, or economic circumstances.

Brief, individual episodes of treatment are not generally sufficient to achieve recovery from an eating disorder. A longer course of intervention is required to address all aspects of the illness and reduce the risk of relapse and chronicity. People may require recurrent episodes of treatment, at different levels in the continuum of care and from different service providers.

Vulnerability to illness continues long after treatment and potentially throughout life. There is therefore a need for services that are sensitive to adults seeking support and for health services to provide treatment for adults as well as youth.

People with eating disorders need to be able to step up and down through an integrated continuum of services, experiencing their care as connected and coherent. These episodes of treatment need to work together to support incremental change towards recovery. Isolated episodes of treatment without coherence between episodes undermine the outcomes of treatment and the confidence of the person in their recovery.

Safe treatment for eating disorders addresses all aspects of the illness – physical, psychological, nutritional and functional – with treatment and support delivered by clinicians from different disciplines and frequently by different health service agencies.

Stepped Care for Eating Disorders

An integrated spectrum of services that is able to deliver the right treatment at the earliest possible opportunity in the development of illness or help seeking, responding flexibly to changes in the person's needs over time.

A. An integrated continuum of services delivering collaborative care across primary, secondary and tertiary levels and across psychiatric and medical services

B. The right treatment delivered in an evidence-based dosage and duration.

Earliest possible opportunity, early in the course of illness, early in subsequent episodes of illness, early in relapse and recurrence and early in help seeking.

An integrated response to eating disorders is characterized by:

A stepped model of care

A range of treatment and support options delivered in varying levels of intensity to meet the differing needs of individuals at each stage of illness, and support transition from intensive treatment to self-management.

Multidisciplinary treatment

Services provided by multiple disciplines and health services working collaboratively together.

Coordinated episodes of treatment

Planned and supported transition between programs and service providers; people with complex needs have access to a case coordinator.

Prioritization of early intervention

Flexible entry and exit at all levels of the continuum of care in a step in/out and step up/down process with re-entry pathways to support relapse prevention and minimization of the impact of recurrence.

Services for adults and children

Services and referral pathways that address the needs of people of all ages including the transition between adolescence and adult services and the need of adults for aftercare and recovery support.

The full continuum and scope of services for people with eating disorders may be provided within a single specialist eating disorders service however, services delivered through general primary and secondary health services will require collaboration between several services all of which deliver a part of the safe response to eating disorders. Eating disorders present challenges to the traditional organisation of treatment for mental illnesses. There is a need for integration and collaboration between physical and mental health services, private and public health services, prevention and treatment, health and community services and between professional disciplines.

8. REFERENCES

The following resources have been used in the development of this report. Further references can also be found in key NEDC documents drawn on in the development of these standards. www.nedc.com.au

AED Report (2011). Eating Disorders: Critical Points for Early Recognition And Medical Risk Management In The Care Of Individuals With Eating Disorders. IL, USA: Academy of Eating Disorders.

Australia and New Zealand Academy for Eating Disorders (ANZAED), (2011). Submission to the Senate Community Affairs Committee regarding the Inquiry into Commonwealth Funding and Administration of Mental Health Services. ANZAED, Sydney.

Australian Institute of Health and Welfare (AIHW) (2007).Young Australians: Their health and wellbeing 2007. PHE 87.Canberra: Australian Institute of Health and Welfare.

Australian Nursing Federation for the Australian Government Department of Health and Ageing. **Competency standards for the advanced registered nurse.** Edited and prepared by Amanda Adria, Sydney, 2005.

American Psychiatric Association (APA) (2006). Practice guideline for the treatment of patients with eating disorders. 3rd ed. June 2006. Washington (DC); American Psychiatric Association (APA) American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

Arcelus, J., Mitchell, A.J., Wales, J., Nielsen, S. (2011). Mortality Rates in Patients With Anorexia Nervosa and Other Eating Disorders: A Meta-analysis of 36 Studies Archives of General Psychiatry. 68(7):724-731.

Australian Government Department of Health (2016). PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care. Canberra, Commonwealth of Australia.

Bardone-Cone, A. M., Harney, M. B., Maldonado, C. R., Lawson, M. A., Robinson, D. P., Smith, R., & Tosh, A. (2010). Defining Recovery from an Eating Disorder: Conceptualization, Validation, and Examination of Psychosocial Functioning and Psychiatric Comorbidity. Behaviour Research and Therapy, 48(3), 194 – 202.

Bower, P. and Gilbody, S. (2005). Stepped care in psychological therapies: access, effectiveness and efficiency, Narrative literature review. British Journal of Psychiatry; 186:11-17.

Bravender, T., Elkus, H., & Lange, H. (2016) Inpatient medical stabilization for adolescents with eating disorders: patient and parent perspectives. Eat Weight Disord. 22(3): 483-489.

Byrne, S.M., Fursland, A., Allen, K.L. and Watson, H. (2011). The effectiveness of enhanced cognitive behavioural therapy for eating disorders: an open trial. Behav.Res. Ther. Apr;49(4):219-26.

Clarke, D. & Polimeni-Walker, I. (2004). Treating individuals with eating disorders in family practice: A needs assessment. **Eating Disorders, 12,** 293-301.

Commonwealth Department of Health and Aged Care (2000). **The Australian Health Care System: An Outline.** Commonwealth Department of Health and Aged Care, Canberra.

Commonwealth Department of Health and Aged Care. (2008). National Mental Health Policy. Commonwealth Department of Health and Aged Care, Canberra.

Crow, S.J., Peterson, C.B., Swanson, S.A., Raymond, N.C., Specker, S., Eckert, E.D., Mitchell, J.E. (2009). Increased Mortality in Bulimia Nervosa and Other Eating Disorders. Am J Psychiatry; 166:1342 – 1346).

Deloitte Access Economics (2012) Economic and Social Cost of Eating Disorders in Australia. Prepared for the Butterfly Foundation, November 2012.

Fairburn, C.G. and Cooper, Z. (2011). Therapist competence, therapy quality and therapist training. Behav Res Ther., 49: 373-378.

Fairburn CG, Cooper Z, Doll HA, et al. (2009). Transdiagnostic cognitive-behavioural therapy for patients with eating disorders: A two-site trial with 60-week follow-up. The American Journal of Psychiatry 166:311 – 319.

Fairburn, C. G., Marcus, M. D., & Wilson, G. T. (1993).Cognitive-behavioural therapy for binge eating and Bulimia Nervosa: a comprehensive treatment manual. In C. G. Fairburn, & G. T. Wilson (Eds.), Binge eating: Nature, assessment and treatment (pp. 361-404). New York: Guilford Press.

Fairweather-Schmidt A & Wade T. DSM-5 eating disorders and other specified eating and feeding disorders: is there a meaningful differentiation? Int J of Eating Disorders. 2015; 47(5) 524-533.

Firth N, Barham M, Kellett S. The clinical effectiveness of stepped care systems for depression in working age adults: A systematic review. J Affect Disord. 2015;170:119-130.

Gill, K.H. (2014). Recovery College, Co-Production in Action: The value of the lived experience in " Learning and Growth" for Mental Health. Health Issues, Summer 2014, 10-14.

Hart, L. M., Jorm, A. F., Paxton, S. J., Kelly, C. M,. & Kitchener, B. A. (2009) First Aid for Eating Disorders. Eating Disorders, 17(5), 357-384.

Hay, P. & Touyz, S. (2012).Cognitive behaviour therapy for bulimia nervosa, anorexia nervosa and the new 'transdiagnostic' approach Treatment and Recovery of Eating Disorders(pp. 109-117). New York: Nova Science Publishers.

Hay, P. J., Mond, J., Buttner, P., & Darby, A. (2008). Eating Disorder Behaviors Are I ncreasing: Findings from Two Sequential Community Surveys in South Australia. PLoS ONE 3(2), e1541.

Hay, P., Chinn, D., Forbes, D., Madden, S., Newton, R., Sugenor, L., Touyz, S. and Ward, W. (2014). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders.

Australian and New Zealand Journal of Psychiatry 2014, Vol. 48(11) 1-62 Hay,P.J., Touyz, S. and Sud, R. (2012) Treatment for severe and enduring anorexia nervosa: A review. Published online 13 June 2012 Aust N Z J Psychiatry

Ho, F. Y., et al. (2016). The Efficacy and Cost-Effectiveness of Stepped Care Prevention and Treatment for Depressive and/or Anxiety Disorders: A Systematic Review and Meta-Analysis. Sci Rep 6: 29281.

Hudson, J. I., Hiripi, E., Pope, H. G. & Kessler, R. C. (2007). The Prevalence and Correlates of Eating Disorders in the National Comorbidity Survey Replication. Biological Psychiatry , 61(3), 348-358.

Human Capital Alliance (International) Pty Ltd (HCA). Written by: David Gadiel, Lee Ridoutt, Vivian Lin, Trevor Shilton, Marilyn Wise and Joanne Bagnulo. **Audit of the Preventive Health Workforce in Australia: Final report of project findings.** Prepared by HCA for the Department of Health and Ageing. Accessed at: www.anpha.gov.au/internet/anpha/publishing.nsf/Content/6760854C01E0DCA6CA257B7E00270F8B/ $File/Th e%20Audit%20Report.Pdf

Joice A, Freeman L, Toplis L, Bienkowski G. A review and discussion of psychological therapies and interventions delivered within stepped care service models. Scotland: NHS Education for Scotland; 2010.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. The Medical Journal of Australia, 166(4), 182-186.

Khan, F. and Chowdhury, U. (2011). Eating Disorders in Children and Adolescents. **BJMP**; 4(1):a405.

Lannfelt, E., Molin, M., Linne von Hausswolff-Juhlin, Y., Norring, C. (2014). Still Ill? Long-term Outcome Ten Years After Eating Disorders Treatment . Paper, International Conference on Eating Disorders, March 2014, New York. http://www.aedweb.org/Poster_Sessions.htm

McCormack, J., Watson, H.J., Harris, C., Potts, J., and Forbes, D. (2013). A hub and spokes approach to building community capacity for eating disorders in rural Western Australia. **Aust. J. Rural Health,** 21, 8-12.

McIntosh. V.V., Jordan, J., Luty, S.E., Carter, F.A., McKenzie, J.M., Bulik, C.M. and Joyce, P.R. (2006). Specialist supportive clinical management for anorexia nervosa. **International Journal of Eating Disorders,** 39(8): 625-632.

Mitchell, J. E., Agras, S., Crow, S., Halmi, K., Fairburn, C. G., Bryson, S., & Kraemer, H. (2011). Stepped care and cognitive‐behavioural therapy for bulimia nervosa: randomised trial. **The British Journal of Psychiatry,** 198(5), 391‐397. http://doi.org/10.1192/bjp.bp.110.082172

Mitchell, J.E., Agras, S., & Wonderlich, S. (2007). Treatment of Bulimia Nervosa: Where are we and where are we going? **International Journal of Eating Disorders,** 40, (2): 95‐101.

Murray, S.B., Griffiths, S., Le Grange, D. (2013). The Role of Collegial Alliance in Family-Based Treatment of Adolescent Anorexia Nervosa: A Pilot Study. International Journal Eating Disorders.

National Eating Disorders Collaboration (NEDC). (2010). **NEDC National Framework: Eating Disorders: The Way Forward.** NEDC, Sydney.

National Eating Disorders Collaboration (NEDC), (2011). Evidence from Experience. A reference group report published as an attachment to the National Framework. NEDC, Sydney.

National Eating Disorders Collaboration (NEDC). (2012). **NEDC National Framework: An Integrated Response to Complexity.** NEDC, Sydney.

National Eating Disorders Collaboration (NEDC). (2013). **NEDC Gap Analysis: A Nationally Consistent Approach to Eating Disorders.** NEDC, Sydney (unpublished).

National Health and Medical Research Council (NHMRC) (2000). **How to put the evidence into practice: implementation and dissemination strategies.** Handbook series on preparing clinical practice guidelines. Endorsed February 2000. Commonwealth of Australia.

National Institute for Health and Clinical Excellence (NICE) (2011). Common mental health disorders: identification and pathways to care. London: NICE; 2011. CG123. http://guidance.nice.org.uk/CG123

National Institute for Clinical Evidence (NICE) (2004). Eating disorders: Core interventions in the treatment. United Kingdom.

NCOSS (2007). Models of Workforce Development. Report to NSW government and non-government sectors.

Noordenbos G., Oldenhave A., Muschter J., Terpstra N. (2002). Characteristics and treatment of patients with chronic eating disorders. **UEDI;**10(1):15 – 29.
NSW Health Department. (1999). Core competency standards for Aboriginal and Torres Strait Islander HIV/sexual health workers in NSW. NSW Health Department, Sydney.

Oakley Browne, M. A., Wells, J. E. & McGee, M. A. (2006). Twelve-month and lifetime health service use in Te Rau Hinengaro: The New Zealand mental health survey. **Australian and New Zealand Journal of Psychiatry,** 40, 855-864.

O'Dea, J. A. (2005). School-based health education strategies for the improvement of body image and prevention of eating problems: An overview of safe and successful interventions. Health Education, 105(1), 11-11-33.

Ogg, E. C., Millar, H. R., Pusztai, E. E. & Thom, A. S. (1997). General practice consultation patterns preceding diagnosis of eating disorders. **International Journal of Eating Disorders,** 22(1), 89-93.

Painter, E., Ward, W., Gibbon, P. & Emmerson, B. (2010). The Eating Disorders Outreach Service: Enabling clinicians statewide to treat eating disorders. **Australian Psychiatry,** 18(1), 49-52.

Pereira, R. F. & Alvarenga, M. (2007). Disordered eating: Identifying, treating, preventing, and differentiating it from eating disorders. **Diabetes Spectrum,** 20(3), 141-148.

Royal Australian and New Zealand College of Psychiatrists (RANZCP), (2011). Addressing the needs of siblings of children with disability or chronic illness.

Rhodes P, & Madden S. (2005). Scientist practitioner family therapists, post-modern medical practitioners and expert parents: Second order change in the eating disorders program at the

Children"s Hospital at Westmead. Journal of Family Therapy; 27:171-82.

Tholking, M.M., Mellowspring, A.C., Eberle, S.G., Lamb, R.P., Myers, E.S., Scribner, C., Sloan, R.F. & Wetherall, K.B. (2011). American Dietetic Association: Standards of practice and standards of professional performance for registered dietitians (competent, proficient, and expert) in disordered eating and eating disorders (DE and ED). **Journal of the American Dietetic Association** 111, 1242-1249.

Walker, S. & Lloyd, C. (2011). Barriers and attitudes health professionals working in eating disorders experience. International Journal of **Therapy and Rehabilitation,** 18(7), 383-390.

Wallace, L.M. & von Ranson, K.M. (2012). Perceptions and use of empirically-supported psychotherapies among eating disorder professionals. **Behaviour Research and Therapy** 50, 215-2.

Williams, M. & Haverkamp, B.E. (2010). Identifying critical competencies for psychotherapeutic practice with eating disordered clients: A Delphi study. Eating Disorders: The Journal of Treatment & Prevention 18, 91-109.

Van Straten A, Hill J, Richards DA, Cuijpers P. Stepped care treatment delivery for depression: a systematic review and meta-analysis. Psychol Med. 2015;45:231-246.

Von Korff, M. and Tiemens, B. (2000) Individualized stepped care of chronic illness. West J. Med; 172: 133-137.
Wade, T. D., Bergin, J. L., Tiggemann, M., Bulik, C. M., & Fairburn, C. G. (2006). Prevalence and long- term course of lifetime eating disorders in an adult Australian twin cohort. Australian and New Zealand Journal of Psychiatry, 40(2), 121-128.

Wallis, A., Rhodes, P., Kohn, M. & Madden, S. (2007) Five-years of family based treatment for Anorexia Nervosa: The Maudsley Model at the Children‟s Hospital at Westmead. International Journal of Adolescent Medical Health 19(3):277-283.

Weiss, C.V., Mills, J.S., Westra, H.A. & Carter, J.C. (2013). A preliminary study of motivational interviewing as a prelude to intensive treatment for an eating disorder. Journal of Eating Disorders 2013, 1:34 http://www.jeatdisord.com/content/1/1/34

Wilson G.T., Fairburn C.C., Agras W.S., Walsh B.T., Kraemer H. (2002). Cognitive-behavioral therapy for bulimia nervosa: time course and mechanisms of change. J Consult Clin Psychol; 70:267 – 274.

Yi-Hao Weng, Ken N Kuo, Chun-Yuh Yang, Heng-Lien Lo, Chiehfeng Chen and Ya-Wen Chiu (2013). Implementation of evidence-based practice across medical, nursing, pharmacological and allied healthcare professionals: a questionnaire survey in nationwide hospital settings. Implementation Science, 8:112

National Eating Disorders Collaboration

The National Eating Disorders Collaboration is funded by the Australian Government Department of Health.

This document was first published in February 2018 and last updated in January 2020.